Office of the Correctional Investigator

A Three Year Review of Federal Inmate Suicides (2011 – 2014)

September 10, 2014

The Correctional Investigator Canada / L'Enquêteur correctionnel Canada

Canada

CAT. No.: PS104-11/2014E-PDF
ISSN: 978-1-100-24847-9

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PRINTED IN CANADA

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Office of the Correctional Investigator of Canada

Final Report

September 10, 2014

Table of Contents

INTRODUCTION 3

CONTEXT 6

METHODOLOGY 9

FINDINGS 10

ANALYSIS 12

- Assessment of CSC's Suicide Prevention Program 12
- Segregation as an Independent Risk Variable 15
- In-Cell Suspension Points 18
- Precipitating Factors 20
- Continuity of Care Issues 23
- Quality of the Post-Incident Investigative Process 24
- Screening and Identification of Suicide Risk 25
- Other Issues of Concern 27

CONCLUSION 28

RECOMMENDATIONS 29

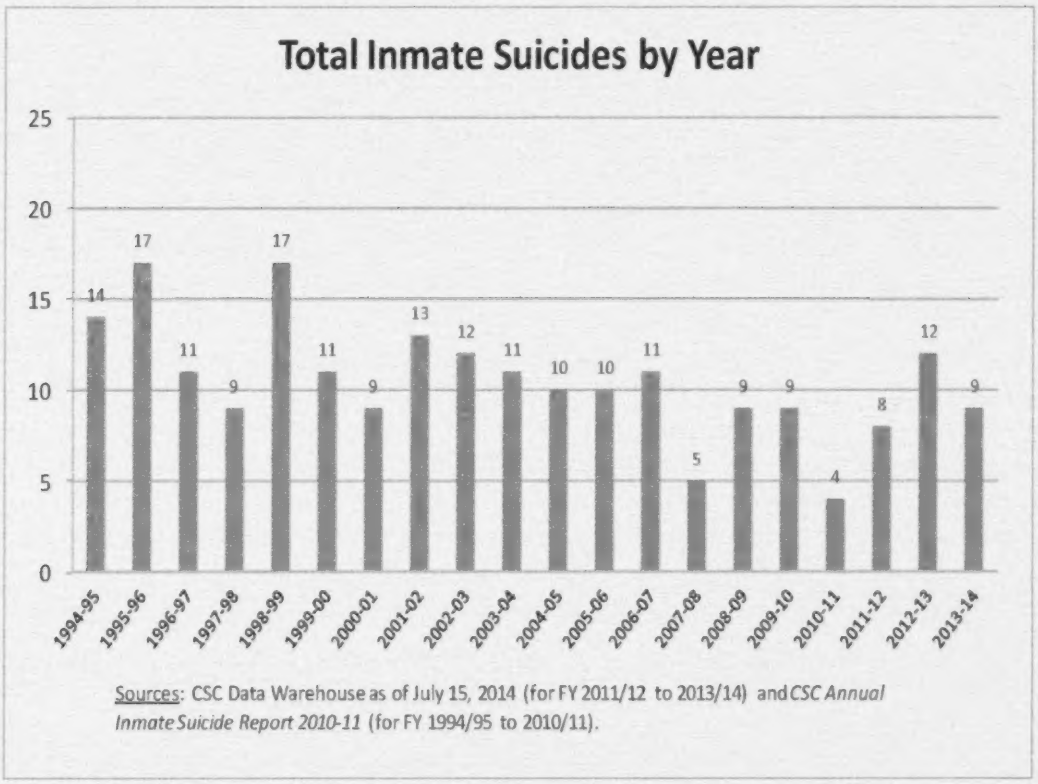
ANNEX 32

REFERENCES 55

A Three-Year Review of Federal Inmate Suicides (2011 – 2014)

INTRODUCTION

Sadly, we have come to expect about ten suicide deaths each year in federal penitentiaries. Though the number of prison suicides fluctuates annually and has generally been declining, the rate has remained relatively stable in recent years and is still approximately seven times higher than in the general population.[1] In the 20-year period from 1994-95 to 2013-14, a total of 211 federal inmates have taken their own life. Suicide is the leading cause of un-natural death among federal inmates, accounting for about 20% of all deaths in custody in any given year.[2]



Sources: CSC Data Warehouse as of July 15, 2014 (for FY 2011/12 to 2013/14) and *CSC Annual Inmate Suicide Report 2010-11* (for FY 1994/95 to 2010/11).

[1] Public Safety Canada, *Corrections and Conditional Release Statistical Overview*, December 2013.

[2] Death by natural causes (cancer, cardiovascular disease) is the leading cause of mortality in federal penitentiaries accounting for two-thirds of all in-custody deaths.

While there is no fail-safe method to predict suicide in a prison setting, there is an obligation on the Correctional Service of Canada (CSC) to preserve life in custody. A comprehensive suicide awareness and prevention program increases the likelihood of identifying and safely managing suicidal inmates.

This report, part of the Office's continuing focus on prevention of deaths in custody, consists of a comprehensive review of all completed acts of suicide (n=30) that occurred in federal penitentiaries in the three year period between April 2011 and March 2014. The Office was prompted to undertake this review in light of a number of concerning developments that, when considered together, suggest that progress has stalled in CSC's efforts to prevent and publicly account for deaths in custody:

1. Persistent concern about the disproportionate number of prison suicides that continue to occur in segregation cells under conditions of close monitoring and supervision. Policy prohibits segregation placements for the purpose of managing suicide risk. Notwithstanding, the Service continues the dangerous practice of long-term segregation of mentally disordered inmates at elevated risk of suicide and/or self-injurious behaviour.

2. Critical findings and recommendations emanating from recently concluded high profile provincial fatality inquiries and inquests into deaths involving federally sentenced inmates.[3]

3. CSC has stopped producing its *Annual Inmate Suicide Report*, an initiative that dates back to 1992.[4] (The last report covered prison suicides that occurred in FY 2010-11).

4. In February 2009, as part of its follow-up to the Office's reports on deaths in custody, the CSC committed to sharing quarterly summaries highlighting pertinent issues and statistical information on deaths in custody (other

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[3] For example see: Report to the Minister of Justice and Attorney General of Alberta, "*Public Fatality Inquiry into the death of Edward Christopher Snowshoe*," (June 2014) and Chief Coroner of the Province of Ontario, "*Inquest Touching the Death of Ashley Smith*," (December 2013).

[4] The *Annual Inmate Suicide Reports* contained an overview of the incidence of inmate suicides in CSC facilities, a description of the suicides that occurred in that year (e.g. method and means of suicide, security level, location, psychological background and suicide risk pre-indicators), as well as a summary of recommendations emanating from CSC Board of Investigation reports.

than deaths by natural causes). The first of six quarterly bulletins (*Deaths in Custody – Highlights and Significant Findings*) was received by this Office in September 2009, with the last bulletin issued in March 2011 covering 17 deaths that occurred between October and December 2010.

5. As a policy streamlining measure, as of April 2014 the Service is no longer conducting suicide risk screening of first-time federal inmates awaiting transfer from provincial remand to federal custody.

6. As it agreed to do, the Service has still not yet posted on its external website its response to the findings and recommendations of *The Final Report of the (Second) Independent Review Committee* (November 2012). Appointed by the Commissioner, this external review body, part of CSC's response to the Office's 2007 *Deaths in Custody* study, examined 25 non-natural deaths in custody (6 suicides, 4 overdoses, 5 homicides, 9 deaths by unknown causes and 1 death by deadly force) that occurred in federal facilities between April 2010 and March 2011.[5]

7. Finally, despite documents that remain in draft and incomplete form, CSC has not yet produced a performance monitoring and reporting framework that would serve to publicly account for its progress in preventing deaths in custody.

The conclusions reached in this report are supported by a review of the current literature on risk factors for prison suicide, the Office's assessment of CSC's suicide awareness and prevention strategy, as well as findings and recommendations from post-incident reviews and investigations. As a synthesis of the findings and lessons learned derived from these sources, this report aims to identify persistent gaps, risks and impediments to CSC's current suicide prevention measures. The report points to a number of organizational weaknesses and calls for improvement in specific areas of CSC's suicide awareness and prevention program:

1. Suicide risk screening and identification (pre-indicators).
2. Monitoring and management of suicidal behaviour.

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[5] The Independent Review Committtee's mandate is broad. It includes an assessment of the appropriateness and adequacy of corrective measures taken by CSC in response to deaths in custody, as well as analysis of precipitating or contributing factors linked to in-custody deaths.

3. Physical infrastructure vulnerabilities (e.g. access to the means and methods of prison suicide, including in-cell suspension points).
4. Quality of the internal post-incident investigative process.
5. Continuity of care concerns.
6. Communication and information sharing issues.

CONTEXT

There are several factors that put incarcerated persons at heightened risk of suicide. By its nature, incarceration entails loss of autonomy and personal control. Deprivation, isolation and separation from loved ones can produce feelings of helplessness and/or despair. In particular, long periods of physical isolation in segregation can intensify such feelings leading one to the conclusion that life is no longer worth living.

Most inmates who commit suicide are unmarried, Caucasian males between the ages of 31-40.[6] They are typically serving a sentence for violence, most often crimes against another person.[7] Current CSC research indicates that one-third of offenders who committed suicide were incarcerated for a violent offence that had resulted in the death of the victim.[8]

The security level of a prison has an important effect on prison suicide rates. In federal corrections, prison suicides most often occur in medium security institutions (where the bulk of the federal incarcerated population is held), nearly always in cells and often when staffing is lowest (between midnight and 0600 hrs).[9] By far, the most common method of prison suicide is by hanging.

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[6] From 1991-92 to 2010-11, six federally sentenced women inmates died by suicide.
[7] CSC, "A Comparative Review of Suicide and Self-Injury Investigative Reports in a Canadian Federal Correctional Population" (2010).
[8] Ibid.
[9] CSC, *Inmate Suicide Awareness and Prevention Workshop: Participant's Manual* (Fall 2012) and CSC (2010).

Significantly, physical isolation with minimal external stimulation or opportunity for social interaction is an important risk factor for prison suicide. A recent CSC study found that 22% of suicides occurred in segregation or segregation-like conditions of confinement and another 11% occurred in a treatment centre (psychiatric hospital).[10] Put another way, one-third of all suicides took place in areas of the prison where there is an enhanced level of observation and monitoring.[11] This finding has remained consistent over the years: comparatively speaking, a disproportionate number of inmates take their lives in segregation as opposed to general population cells.

In terms of the length of sentence, offenders who are most likely to commit suicide tend to fall into two general categories: those with a life sentence and those serving less than 5 years.[12] Research suggests that the most vulnerable time with respect to suicide is the initial phase of incarceration (first 90 days or within one year of commencing a sentence). By contrast, a life sentence often results in feelings of despair and hopelessness, which can increase the risk of suicide.

Similar to suicides that occur in the general population, having a mental health problem or diagnosis or compromised mental health functioning appears to be a significant risk factor for prison suicide.[13] Recent research on suicide in federal penitentiaries found that 44% of offenders who committed suicide between 2003/04 and 2007/08 had file evidence of a diagnosis of one or more psychological disorders.[14] The Prisons and Probation Ombudsman for England

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[10] CSC (2010).

[11] Other studies indicate that a disproportionate percentage (as high as 79%) of suicides occur in cells where prisoners are physically separated from the general population.

[12] Seena Fazel et. al. "Suicide in Prisoners: A Systemic Review of Risk Factors," *Journal of Clinical Psychiatry* (November 2008).

[13] Norbert Konrad et. al. "Preventing Suicide in Prisons, Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons," *Crisis*, 28:3 (2007); United States Department of Justice: National Institute of Corrections. *National Study of Jail Suicide: 20 Years Later* (April 2010); Prisons and Probation Ombudsman for England and Wales, *Learning from PPO Investigations: Self-Inflicted Deaths of Prisoners on ACCT* (April 2014) and *Risk Factors in Self-Inflicted Deaths in Prisons* (April 2014).

[14] CSC (2010).

and Wales recently found that three-quarters of prisoners who took their life in prison had mental health issues.[15]

Beyond a history of mental illness, strong associations with prison suicide have also been found with respect to following pre-indicative risk factors:

- Recent suicidal ideation, intent or prior attempt.
- Concurrent substance abuse disorder.
- History of self-injurious behaviour.
- High prevalence of depression, despair and/or hopelessness.
- Poor social and/or family supports.
- Family history of suicide (especially first degree relatives).

As in the community, prison suicide rarely occurs without pre-indicators – signs, symptoms, warnings. Data from 98 suicides[16] in CSC facilities that occurred in the ten year period between 2000/01 and 2009-10 indicates the following contributing risk factors:

- Most (58%) had a history of psychological problems.
- Most (60%) had made previous suicide attempt(s).
- Over one-third had a history of self-injurious behaviour.
- Most (85%) had been identified as having difficulties in the past with substance abuse.

While there is no typical person or profile that is predisposed to commit suicide, particular events and circumstances unique to incarceration can cause increased stress, anxiety and fear leading to elevated risk: change in personal circumstances (e.g. loss of a loved one, divorce, family problems); significant event (child's birthday, anniversary or major holiday); and change in sentence administration (transfer to another institution, denial of parole, loss of appeal, new charges). The case summaries annexed to this report illustrate several clear contributing or precipitating factors among those who died by suicide in federal penitentiaries.

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[15] Prisons and Probation Ombudsman for England and Wales (2014).

[16] CSC, *Inmate Suicide Awareness and Prevention Workshop: Facilitator's Manual* (Fall 2012).

METHODOLOGY

The Office conducted a file review of all inmate suicides (n=30) that occurred in federal penitentiaries in the three year period between April 2011 and March 2014. This time period coincides with CSC's decision to discontinue producing its annual inmate suicide reports. Information was primarily obtained from the reports of the National Boards of Investigation (NBOI) which are convened after each suicide by the Commissioner.[17] At time of this review, 25 of the 30 investigation reports had been received by the Office. Information for cases where the investigation had not yet been convened or received by this Office in final copy was gathered through Warden Situation Reports and the Offender Management System.[18]

Consistent with the Office's focus on raising awareness of systemic or organizational gaps, available records from provincial Coroner inquests and fatality inquiries were reviewed with the intent of assessing jury findings and recommendations that might help prevent similar deaths in the future. CSC's suicide prevention and awareness program, including staff training materials and policy framework, was also reviewed and assessed as part of this report. Finally, a select review of the current literature on prison suicide supported the Office's analysis of post-incident reviews and records.

Case summaries of ten suicide deaths were also prepared. The summaries are annexed to this report. These cases were purposefully selected to illustrate system-wide issues and concerns in preserving life in a correctional context. Though identities are protected, each case presents a unique set of events and

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[17] A suicide death in custody is investigated by the Service under section 19 of the *Corrections and Conditional Release Act*. The Board of Investigation (or BOI) that is convened produces a standardized report that includes a description of the events prior to and after the incident leading to death, as well as a review of policy and legal compliance. For suicides, the Board normally includes a psychological review of the inmate's profile. An external community member is appointed to the Board. The findings of BOI reports are used to develop and implement corrective measures as appropriate.

[18] For purposes of this review, one overdose death was counted as a suicide because, in the Office's view, there was sufficient evidence to point to that conclusion. One other case of an inmate who died of dehydration was not counted as a suicide. Finally, it should be underlined that some more recent deaths categorized as "unknown" cause (and for which the NBOI and/or Coroner inquest determining cause of death has not yet been concluded) may later be considered as suicide deaths.

precipitating circumstances. The summaries are compelling in their own right as they put a human face on a problem that is often portrayed as inevitable or unavoidable no matter what prevention efforts or measures may be in place. As the literature and this report make clear, prison suicide rarely occurs without pre-indicator(s) or under circumstances not previously identified as contributing to risk.

FINDINGS

Inmates under 40 years of age represented half of the 30 suicides reviewed by the Office. The median age was 45 years old. 16 of 30 suicides were Caucasian. One-third were of Aboriginal ancestry. Three were Black. Almost half (n=14) were incarcerated in medium security institutions, followed by maximum security (n=9). At time of death, three inmates had not yet been classified: in one case, the suicide occurred after only 14 days of admission to federal custody; in a second case, the offender committed suicide while suspended from a long-term supervision order; and the third case involved an offender who had been classified as medium security, but was being held awaiting transfer to the segregation unit of a maximum institution.

Nearly all inmates (27 of 30) died by asphyxiation (25 by hanging).[19] A suicide note was found in half of the sample (n=24) from which information was available. 19 of 25 inmates had previously attempted suicide; seven more than twice. Nearly one-in-four had expressed suicidal ideations in the days immediately leading up to their death. 14 of 25 inmates were prescribed psychotropic medication(s) for mental health issues. Most had a documented concurrent substance abuse (alcohol and/or drugs) disorder.

Significantly, of the 30 cases reviewed by the Office, 14 suicides occurred while the inmate was in segregation. Only one segregated inmate was being actively managed on suicide watch at the time of his death, though at least three others were being monitored. Nearly all segregated inmates had known significant mental health issues; most were or had been referred and/or seen by

[19] Other causes of death included: one overdose, one death from trauma and one from exsanguination (significant blood loss).

mental health staff while on segregation status, some on a regular basis. The majority of segregated inmates had a history of previous suicide attempt(s), suicidal ideation and/or self-harming behaviour. At least half had spent a previous period in segregation on mental health monitoring status. All had completed the *Immediate Needs Checklist Suicide Risk*. Several had been transferred in-and-out of regional treatment centres (psychiatric hospital) over the course of their incarceration.

In terms of time spent in segregation before death, three inmates took their lives within 5 days of the placement. Three others committed suicide between 15 and 30 days in segregation and another two had spent between 30 and 60 days. Notably, three inmates completed suicide after being segregated for more than 120 days on a continuous basis. Another inmate was kept on perpetual segregation status that lasted years right up to his death. One other had spent most of his sentence in segregation-like conditions of confinement with alternating placements in observation cells on suicide watch and in the Special Handling Unit, often while in restraints.

With respect to other pre-indicators, one segregated offender was a month away from his warrant expiry date and the mother of another had just died before his suicide. Suicide notes were found for seven of the 14 inmates who took their own lives in segregation cells, an indication that suicidal intent (plans and preparations) had been formed in advance of the act.

The reason for segregation varied: some were held voluntarily (at their own request); some involuntarily (for their safety or that of the institution); and a few were in segregation for disciplinary reasons. One chronic "high-risk" suicidal inmate, who had attempted suicide at least six times in the last two years of his life, had been under various suicide watch observation levels or mental health monitoring status for months and was being actively followed by a treatment team for self-injury and suicidal ideation.

ANALYSIS

Assessment of CSC's Suicide Prevention Program

According to the literature, a comprehensive suicide prevention program contains a number of integrated measures and interventions, including but not limited to these major areas of focus:

1. Screening, Identification and Assessment of Suicide Risk (conducted by mental health professionals)

2. Staff Training in Suicide Awareness and Prevention

3. Clear Referral and Treatment Procedures

4. Protocols for Monitoring and Management of Suicidal Behaviour

5. Physical Environment (suspension points and blind spots identified, removed and/or mitigated to the safest extent possible)

6. Communication – information sharing involving past or recent behaviour of suicidal inmates between staff (correctional officers, medical and psychiatric personnel), within institutions and between jurisdictions

7. Interdisciplinary Approach – suicide should not be viewed strictly as a security matter or as entirely a medical problem

8. Intervention – procedures on how to handle a suicide attempt in progress

9. Notification – in the event of a suicide, appropriate officials and family members must be notified.

10. Critical Incident Stress Debriefing – trained professionals in crisis intervention and traumatic stress awareness for **both** staff and inmates.

11. Reporting and Review – appropriate reporting procedures, administrative and medical reviews with periodic audits of the overall prevention strategy

The Office's assessment of CSC's suicide prevention strategy suggests that these protocols and practices are in place in federal corrections, a finding also supported by the Second Independent Review Committee (November 2012).[20] Commissioner's Directive 843 (*Management of Inmate Self-Injurious and Suicidal Behaviour*) provides the overall policy framework for managing inmates on suicide precautions – e.g. suicide watch observation levels, screening for suicide risk, prohibited items. The frequency and intensity of mental health monitoring is determined by a mental health professional. For example, inmates on High Suicide Watch (imminent risk) are under constant, direct observation and access to various means by which they could harm themselves (clothing, bedding, cutlery and other personal effects) is severely restricted. As previously mentioned, policy specifically prohibits segregation placements for the singular purpose of managing suicide risk. Suicidal inmates are to be managed by way of the mental health observation protocols specified in Commissioner's Directive 843.

Every inmate is required to undergo mental health screening (*Immediate Needs Checklist for Suicide Risk*) within 24 hours of admission, upon transfer/arrival at a new institution and when placed in segregation. Though often administered by front-line security staff, the *Checklist* provides for a mental health referral process.

With respect to administrative segregation, a nurse must meet with the inmate at time of admission to establish if there are any health concerns.

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[20] *The Final Report of the Independent Review Committee into Federal Deaths in Custody 2010-2011*, submitted by Dr. Michael Weinrath (Chair), Dr. Tristan Wayte and Dr. Julio Arboleda-Flórez (November 2012).

Thereafter, the inmate is to be seen by the nurse on a daily basis. A mental health professional must assess and report on the mental health status of the offender, with a special emphasis on the evaluation self-injury or suicidal risk, within the first 25 days of initial placement and once every subsequent 60 days of segregation. The Institutional Parole Officer is to meet with the segregated inmate within two working days to explore alternatives to segregation.

CSC offers a suicide awareness and prevention workshop for inmates that provides a basic level of suicide awareness. An inmate peer support program is also active in the five regional women's facilities.[21]

In October 2013, the scope of the Regional Suicide/Self-Injury Prevention Management Committee was expanded to include offenders with complex mental health needs, as well as offenders who persistently and chronically engage in self-injurious behaviour. The expanded Regional Complex Mental Health Committees meet monthly to review complex cases, focusing on chronic self-injurious inmates, flagging items of concern and consulting/engaging institutions to offer support and advice in the management and treatment of offenders with complex mental health needs.[22]

Mandatory staff training includes a two-day course in the *Fundamentals of Mental Health*, which incorporates basic information on suicide prevention and self-injurious behaviour in prison. CSC's New Employee Orientation Program contains an "optional" self-directed learning module (1.5 hours) on suicide awareness for National Headquarters (NHQ) staff while a self-directed and in-class session is required for staff members in the regions who have direct contact with offenders.[23] Modules on suicide prevention are also incorporated into the

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[21] The VIVA initiative (Voluntary Investing in a Viable Affective Life), an inmate peer counselling program that operated at a few male facilities, is no longer active.

[22] In reviewing the minutes of the Regional Complex Mental Health Committees, it appears that they are primarily if not exclusively focused on inmates who chronically engage in self-injury. As CSC policy recognizes, self-injury is "the intentional, direct injurying of body tissue without suicidal intent." The extent to which the Regional Committees are involved in overseeing the treatment and management of individual inmates on active suicide watch precautions (e.g. Commissioner's Directive 843) is unclear from the documents provided by the Service.

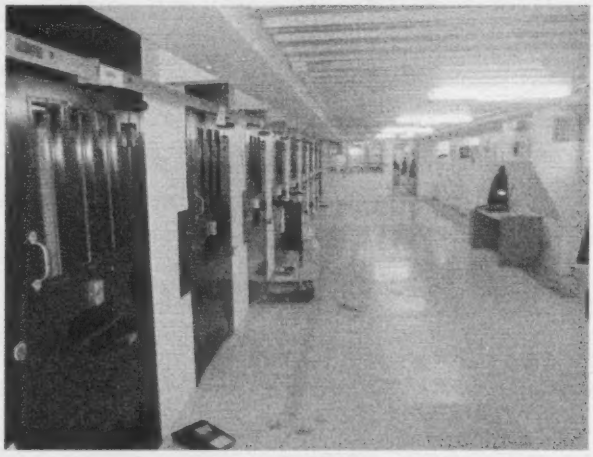
[23] Some experts in suicide prevention question the utility and value of self-directed, e-learning, question-and-answer modes of instruction as alternatives to classroom training, as well as

Correctional Training Program and Parole Officer Induction Training. Refresher training in suicide prevention and intervention is mandatory for front-line staff consisting of an annual online session (1 hour) and an in-class session (2 hours) every two years. Front-line staff are also trained in basic emergency response. After a suicide, Critical Incident Stress Management (CISM) de-briefing is offered to staff members, but not inmates.

With respect to reporting and review procedures, by law CSC is required to investigate all deaths in custody. Suicide deaths are subject to a National Board of Investigation (or NBOI) convened by the Commissioner. Provincial and Territorial Coroner or Medical Examiner offices conduct independent inquests into some prison suicides.

In CSC's case, the issue is not that it lacks a suicide prevention strategy, but rather how well the component parts of the interdisciplinary approach come together to identify, monitor, communicate and safely manage suicide risk.

Segregation as an Independent Risk Variable



A major finding of this review, one that is repeatedly supported by the literature, is that suicide rates are more prevalent in physically isolated cells (segregation, observation and mental health cells) than in general population cells. The literature is also clear that physical isolation and separation increases the risk of suicidal behaviour. Placement of a mentally disordered inmate in segregation or in an observation or special suicide-resistant cells has both perceived and actual

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training that is only provided to comply with an accreditation or induction standard of some kind. As Hayes, op. cit, (2013) points out: "The topic of suicide prevention is one that is best provided in a live, interactive environment amongst correctional, mental health, and medical personnel."

punitive aspects. Mental health observation placements, for example, typically involve, among other measures, mandatory strip search, issuance of anti-suicide garments, removal of personal items, constant direct observation (via closed-circuit television, staff or both), limited association and restricted access to showers, visits and phone calls. These factors can be expected to elevate rather than reduce suicidal tendency. Behaviours driven by underlying mental illness are not modified or corrected by measures that are perceived to be punitive or depriving. As this Office has long advocated, long-term segregation of mentally disordered inmates or those at risk of suicide or serious self-injury should be prohibited. Such a prohibition would be more consistent with existing policy on managing suicide risk than the status quo.

The fact that only one inmate took his life while on official suicide watch protocols suggests that mental health monitoring precautions, when combined with treatment and counseling that is commensurate with risk, can help prevent those at imminent risk of completing acts of suicide. However, for the overwhelming majority of inmates who took their lives in segregation cells, the placement appears to not have been safe, regardless of the length or purpose of the placement. Segregation did little to respond to the inmate's underlying mental health distress and may, in fact, have been an independent contributing factor. Aside from crisis intervention, there is little or no capacity in a segregation range to provide counseling, let alone deliver a potentially life-saving therapeutic response. In one case, though it was well known to CSC that the stress of long-term segregation was a risk factor in the inmate's suicidal behaviour, he was still held in that condition right up to the point that he took his own life. Another inmate was placed in segregation as a response to his self-injurious behaviour, which staff perceived to be malingering and manipulative in nature. In distress and in need of help, his self-injurious behaviour was met by a form of discipline and punishment that ultimately, if unintentionally, precipitated his death.

For the 14 suicides that occurred in segregation, the *Immediate Needs Checklist – Suicide Risk* had been completed and most had been seen by a health care professional at some point. However, in at least two cases, although the inmates had been referred to a mental health care professional, they were never

seen. In one case, the nurse responsible for completing the 24 hour assessment referred an inmate to Psychology; however, the referral was never date stamped or actioned due to administrative staff shortages in the Psychology department. In another case, Psychology made a decision not to assign an inmate to a mental health professional, despite a history of diagnosed mental health issues, again due to staff shortages as well as a breakdown in information-sharing.

Given the disproportionate number of suicide deaths that take place in non-general population cells, there is a need for CSC to understand these placements as independent factors that must be mitigated as part of its suicide risk prevention program. Put more simply, there is something about conditions in segregation that increase the potential for vulnerable inmates to act on suicidal ideation. Segregation is often described as a "prison within a prison." Held in the most austere and depriving conditions possible under the law, for some inmates a segregation placement increases suicidal thoughts and acts that can lead to death.

There is emerging international consensus that there are harmful impacts of long-term segregation on mental health functioning. Indeed, the United Nations Special Rapporteur of the Human Rights Council has called for an absolute prohibition on the use of segregation in excess of 15 days and has further declared the practice of solitary confinement of persons with known mental disabilities of any duration as being cruel, inhuman or degrading treatment, and, as such, in violation of international law.[24] It is significant to note that ten of the 14 inmates who committed suicide in segregation cells in this investigation were beyond the 15 day mark; five, in fact, had been held in segregation for more than 120 days prior to taking their life.

Finally, the fact that segregated inmates had both the means and opportunity to end their lives in an area of the prison that is supposed to be safe and subject to constant monitoring represents a serious organizational weakness in CSC's suicide prevention strategy. In terms of means and method of suicide, 11 of the 14 deaths that occurred in segregation cells were by hanging. In-cell

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[24] See, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment* (August 2011).

suspension/anchor points in these cells included: window (5); vent (3); cell bars (1); fire detector (1); shelf (1). Bed sheets were used in 7 suicides, electric cord in 2, and shoe laces in 1.

In-Cell Suspension Points

It is significant to note that a Security Bulletin entitled, *Infrastructure Vulnerabilities – Points of Suspension and Suicide Prevention*, promulgated in January 2010, directed that: "all potential points of suspension, both removable

(i.e. furniture, shelving) and non-removable (i.e. electrical outlets, air vents), and other cell vulnerabilities (i.e. protective covers that have been tampered with or removed) are systematically and consistently identified, inspected, repaired, replaced, repositioned or removed." Consistent with this national directive, in March 2010 the Service reported to this Office that: "We (CSC) are in the process of acting upon a full scale identification of infrastructure vulnerabilities linked to deaths in custody, such as cell call buttons and observation sight lines, that has taken place during the past year at every one of our correctional facilities and we are now taking stock of the physical implementation of those measures."[25]

Noting that progress had stalled on this initiative, in its 2011-12 Annual Report the Office made the following recommendation: "that CSC immediately

[25] CSC, "Updated Progress Report on the August 14, 2009 Correctional Service of Canada (CSC) Response to the Office of the Correctional Investigator's Deaths in Custody Study, the Correctional Investigator's Report: A Preventable Death and the CSC National Board of Investigation into the Death on an Offender at Grand Valley Institution for Women" (March 2010).

put in place all necessary measures, including funding, to ensure that potential points of suspension in inmates' cells are identified and appropriately dealt with to prevent suicide." CSC responded that, while it supports this recommendation in principle, "absolute elimination of any form of suspension point is not feasible ... Nonetheless, CSC strives to eliminate unnecessary suspension point opportunities and more importantly, where it is not feasible or practical to do so, our goal is to ensure that frontline staff are aware of any vulnerabilities in every cell before placing an offender in a cell who may have tendencies toward self-injuring or suicidal behaviours."

It is evident from this review that there are still many points of suspension accessible to inmates. Contrary to the 2010 directive, known suspension points have not even been removed or eliminated from segregation cells, the most vulnerable area of the prison and where a disproportionate number of inmates attempt and complete acts of suicide. It is difficult to comprehend why some of these cells are still in use for segregated inmates, especially in some of the older institutions. The CSC must account for why it continues to accept such a high degree of organizational risk, one that gives potentially suicidal inmates placed in segregation access to the means (and opportunity) to take their life.

In a particularly egregious case, a self-injurious inmate considered a "chronic suicide risk" who had been on high and modified suicide watch for several days just prior to his suicide was removed from mental health monitoring and transferred to a regular cell of a "supermax" range that contained, in the board of investigation's words, a "multitude of suspension points" (e.g. protective bars on the window, an electric box, hanging shelves, exposed light fixture near the ceiling). He eventually took his life by hanging himself from the protective cover of the smoke detector. The Board concluded its investigation noting that there were no consistent or equivalent national standards to manage CSC's effort to identify and remove suspension points. Leaving each institution to its own discretion to determine identification and removal criteria generates gaps and (resource) inequalities in the elimination measures.

As recently as March 2013, another board of investigation made a national recommendation that CSC designate a branch at its National Headquarters to be

responsible for managing the effort to reduce the number of suspension points in cells across the country.[26] In the specific case under review, the inmate had used a vent as a suspension point that had been identified as a potential risk, but had not been included in the national report on suspension vulnerabilities. Moreover, the institution had determined that nothing could be done to alleviate this particular infrastructure risk, a conclusion that was later questioned by the board of investigation. In this case, the segregation placement was especially critical as this inmate was considered a serious suicide risk by his treatment team – especially if placed in segregation. He was nonetheless transferred to segregation from the acute needs unit of mental health centre due to disruptive behaviour. A gap in communication left the inmate without monitoring for a short period of time (less than 20 minutes) in which he managed to complete suicide.

Precipitating Factors

Prison suicide rarely occurs without pre-incident indicators, precipitating events or contributing risk factors. As one commentator puts it: "Suicide is not a bizarre or incomprehensible act of self-destruction. Rather, suicidal people use a particular logic, a style of thinking that brings them to the conclusion that death is the only solution to their problems. The style can be readily seen, and there are steps we can take to stop suicide, if we know where to look."[27] The fact that

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[26] The reasoning behind this particular board of investigation recommendation mirrors that made by the Office in its *Final Assessment of the Correctional Service of Canada's Response to Deaths in Custody* (September 2010), namely that, CSC "should create a senior management position exclusively responsible for promoting, monitoring and ensuring Safe Custody practices." In response, the Service has twice rejected this measure on the basis that Safe Custody is the "responsibility of all operational management positions at the local, regional and national level." It is significant to note that the January 2010 national directive on identification and removal of in-cell suspension points does not identify an office or person of primary interest or responsibility at National Headquarters. Though a spreadsheet of potential vulnerabilities related to physical infrastructure, cell design and cell contents was completed for each institution, the directive simply instructs that the "Regions should continue to focus their efforts to mitigate the identified vulnerabilities." It is not clear whether there were any specific timelines, dedicated resources, technical standards or a follow-up audit that would indicate national progress (or gaps) in complying with this important safe(r) custody initiative.

[27] As cited in Lindsay Hayes, "Suicide Prevention in Correctional Facilities: Reflections and Next Steps," International Journal of Law and Psychiatry, 36 (2013).

a suicide note was found in half of the cases in our sample for which investigations have been completed serves as a reminder that suicidal intent is often formed in advance of the act.

Surprisingly, the boards of investigation typically offer very little comment regarding suicide notes beyond the fact that one was found. Simply understood, a suicide note reflects suicidal intent. While impulsivity may have played a part in the final moments leading up to the commission of the act (e.g. selection of method or opportunity to act), for at least half of the suicides under review there was prior thought and planning that went into its completion. In fact, the occurrence of 'clean' (or "spur of the moment") suicide both in prison and community settings is exceedingly rare. Having a current plan and communicating it indicates suicidal ideations that are serious.

In one case under review, an inmate had told a Psychologist that he was "planning to kill himself in the shower by cutting his jugular vein with a razor" less than a month before his death. He had a lengthy history of suicidal ideation and attempts as well as self-injurious behaviour. He bled to death on the floor of his segregation cell after cutting his carotid artery using a disposable razor attached to two craft sticks secured with dental floss.

In retrospect, several inmates (even those placed in segregation) had access both to the means and method by which they intended to commit suicide; they had made preparations beforehand, and; they followed through on their suicide plan when the opportunity presented itself. In these respects, the majority of the suicides under review cannot be dismissed as impulsive or incomprehensible acts. Nearly all of the investigative reviews conducted by CSC find precipitating events, indicators or risks that could have reasonably been determined to have contributed to the suicide (e.g. previous suicide attempts, family history of suicide, history of psychiatric or psychological disorder). In a number of cases, the reports identify recent *known* or noticeable alterations in mood, thought or behaviour, but these were often found to have been missed, ignored or not taken seriously at the time of the incident.[28]

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[28] CSC has recently added a new term of reference to its investigations of suicides: "the existence of pre-incident indicators, precipitating events or contributing factors ... known by

One suicide note addressed to the inmate's Psychologist contained this apology: "I'm sorry I know I gave you my word. After you left and I went back to my cell thinking I would not hurt myself. As time moved on all that came to mind was hurting myself. You must understand that I cannot go on with life ... I'm doing it because I don't feel safe anymore as a prisoner." In this case, the inmate had "contracted for safety" with a Psychologist just hours prior to his suicide at the conclusion of a crisis counselling session. Contracts with suicidal inmates are often developed in the hope of obtaining assurances that they will not engage in suicidal behaviour. A controversial practice even in the community, there is emerging evidence to suggest that once an inmate has formed suicidal intent, the written or verbal contract is no longer sufficient to prevent suicide. The alternative to contracts for safety is suicide watch precautions, which can drastically impact on residual freedoms and potentially disrupt the therapeutic relationship between mental health professionals and their patients. Each case is unique, and its management relies on professional mental health judgement.

In another case, an inmate with an extensive history of self-injurious behaviour was regarded by CSC staff as manipulative, as a way of controlling or directing situations to his favor. This mindset meant that many self-injurious incidents were not appropriately documented or reported to mental health staff. The day before the inmate committed suicide, he engaged in an act of self-injury that was serious enough to warrant further evaluation and treatment at an outside hospital. This incident, like the others, was considered to be manipulative in nature and was not reported to mental health professionals (as required in Commissioner's Directive 843, *Management of Inmate Self-injurious and Suicidal Behaviour*). As a result, the inmate's risk for a further act of self-injury was not assessed. Incredibly, approximately one hour before his suicide, the inmate was served with a charge sheet for damaging government property the previous day during his act of self-injury. In a rare preventive finding, the board of investigation identified the incident of self-injurious behaviour that resulted in hospitalization as an immediate trigger that, had it been properly

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staff and was any attention provided or action taken by them." The new guideline includes definitions and examples.

followed up, could have "prevented the attempted suicide and subsequent death of the inmate."

Continuity of Care Issues

In some of the cases reviewed by the Office, prior to taking their life the inmate had spent a considerable amount of time at a Regional Treatment Centre (RTC), which are designated and accredited psychiatric hospitals. One inmate had spent eight months at a treatment centre and was reportedly managing well. He committed suicide five days after being transferred back to the segregation unit of his parent institution. Another inmate, who was in-and-out of the treatment centre over an extended three-year period, committed suicide less than four months after being transferred back to the segregation unit of his parent institution. Significantly, when making recommendations few boards of investigation seriously consider the possibility of intermediate mental health care units that could offer a more therapeutic environment than segregation for inmates discharged from the treatment centres and returning to their home institutions. Unfortunately, the Service has yet to develop capacity for intermediate mental health care in male facilities despite being identified as important continuum of care component in its 2004 Mental Health Strategy.

Continuity of care issues, including limited access to mental health services, professionals and supports except for crisis interventions as well as the quality of treatment and response capacity, continue to impede CSC's prevention efforts. For lack of any other perceived or actual alternative, the resort to a non-therapeutic intervention in response to mental illness is a pervasive practice across the Service, especially in the higher security institutions, as if behaviours driven by underlying mental health issues can somehow be modified or expected to improve through further security, separation and isolation measures in non-general population cells. CSC still continues to accept the risk of placing seriously mentally ill, suicidal and self-harming individuals in segregation for "behavioural" reasons (e.g. acting out, malingering). Segregation is still the most commonly resorted to option and response to disruptive behaviour.

Situation and investigative reports indicate that medication adjustment issues (psychotropic medications that had been recently initiated, changed or discontinued) was noted in at least four suicide deaths in segregation. One offender had just been suspended from the methadone maintenance treatment program prior to taking his life. In another case, medications prescribed for mental health issues were not administered during an inter-regional transfer. Upon arrival at the new institution, the inmate voiced concerns to a number of staff about his missed medication. While his medication was administered the following day, the inmate again became concerned when he was informed that the psychiatrist at his new facility had changed the dosage and type of medication that he was prescribed. Two days before his suicide, the inmate reported to a nurse that his mind was racing and that he was experiencing disorganized thoughts. And in yet another case, a prescription was changed to a drug with a documented adverse effect, which the board of investigation identified as a "potential contributing risk factor" to his suicide. Psychotropic medication management seems to be an area of organizational practice that deserves much more attention within CSC, and from boards of investigations looking at suicide deaths that may be linked to deleterious side effects from changes in prescription drugs.[29]

Quality of the Post-Incident Investigative Process

Even after presenting findings of non-compliance or identifying gaps in policy or procedure of one kind or another, it is surprising the number of board of investigation reports that conclude that nothing could have been done to prevent the suicide; despite best efforts, the inmate still managed to conceal suicidal intentions and successfully act upon them. Indeed, most reports conclude that the death was not foreseeable (and therefore) not preventable in any way. It is rare for a Board of Investigation to go the extra step to identify how the death *might* have been averted had staff acted or decided in a different manner.

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[29] A similar critical finding – trend in medication management – was noted in the Second Independent Review Committee's report. The Office has identified prescription drug management as a subject for systemic investigation.

Though the Service goes to considerable length to preserve the professional autonomy of board members, inclusive of community appointments, at the end of the day these are still largely internal investigations conducted by staff members. While the individual board members have extensive experience and knowledge of corrections and the factual findings of most boards are comprehensive and of a consistently high quality, CSC members investigating other CSC staff lack both functional and organizational independence.

For these reasons, the conclusions reached through CSC's internal reviews of prison suicide appear limited as much by the investigative process as they are by the mindset of how the Service approaches and conducts a Section 19 death in custody investigation. The main focus of a board of investigation is too often on policy and procedural compliance and only peripherally touches on prevention of future occurrences. Indeed, in most cases, compliance appears to be both the start and end point of the investigative process. Furthermore, prison suicide is often approached as an isolated and rare event. In spite of the production of incident-specific "discussion guides" related to cause of death, there is often little effort to summarize or collate findings from other similar deaths in custody investigations or ensure lessons learned from one incident to another are shared widely across the Service. To adequately focus on prevention, CSC needs to more fully explore the "*why*" behind compliance. It needs to more properly focus on mitigating organizational gaps, risks and vulnerabilities.

Screening and Identification of Suicide Risk

> A lack of inmates on suicide precautions should not be interpreted as meaning there are not any currently suicidal inmates in your facility, nor a barometer of sound suicide prevention practices ... In fact, the opposite is probably true. We cannot make the argument that our correctional systems are increasingly housing more mentally ill and/or other high risk individuals and then state there are not any suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be a 'zero' number of inmates on suicide precautions; rather the goal should be to identify, manage and stabilize suicidal inmates in our custody.[30]

[30] Cited in Hayes, op. cit. (2013).

CSC continues to struggle with identifying inmates who are not on suicide precautions, but perhaps should be. In the cases reviewed by this Office, it is significant that only a handful were actively under some form of mental health observation at time of their death. Safely managing suicide risk is not easy, but the essential first step is to identify vulnerable individuals. A partial, though not exhaustive list, of inmates at elevated risk would include:

- Those with recent or active self-injurious histories.
- Those who emphatically deny suicidal ideation, but whose psychiatric history and behaviour suggest otherwise.
- Those who contract for safety.
- Those afflicted with psychiatric disorder(s) and whose psychotropic medication(s) has been initiated, or recently changed or withdrawn.
- Those withdrawing from drugs or alcohol
- Those with psychiatric and concurrent substance abuse disorders.
- Recent transfers, especially from lower to higher security facilities.
- Mentally disordered offenders held in segregation.

The important point about screening and identification is that suicide risk is variable and dynamic; there are certain risks that indicate with age, offence type, sentence length. Stresses encountered during the course of a sentence can increase risk (e.g. receipt of bad news during a court or parole hearing, phone call, family or legal visit, dissolution of relationship, or uncharacteristic behaviours such as depression, withdrawal, giving away of personal effects). Suicide screening and identification should not be a single event at admission, or assessed only at crisis points, but rather continuously monitored during and throughout confinement.

The CSC does complete an *Immediate Needs Checklist for Suicide Risk* prior to segregation placement. However, given that 14 of 30 inmates who took their lives in the last three years did so in a segregation cell, it appears that this particular screening tool (and/or its administration) is not necessarily a reliable

predictor of identifying suicidal intent. It is rare for any person to voluntarily admit to another that they are thinking about or have a plan to kill themselves, let alone an inmate revealing self-destructive thoughts to a front-line officer. While tools such as checklists and scoring systems for estimating suicidal risk have their place in corrections, they are of limited value or use in identifying latent suicidal intention among inmates placed in segregation. A checklist for suicide risk upon admission to segregation, even with the possibility of referral, should not substitute for a proper and comprehensive mental health assessment conducted by a mental health professional. A health care referral by security staff is only as good as the follow-up. Relying on self-referrals by inmates is equally problematic.

Other Issues of Concern

There are three other persistent areas of concern noted in CSC's suicide prevention efforts:

1. Problems with the quality of security patrols, counts, live body verification and dynamic monitoring of suicide risk throughout incarceration.
2. Concerns with emergency response: staff not carrying proper life-saving equipment; protracted delays in making emergency 911 calls; and delays in locating and using life-saving equipment.
3. Information-sharing failures: lack of communication amongst and between front-line security staff and health care providers; and breakdowns between institutional authorities involving inmate transfer.

These and other findings of this report are consistent with a number of other reports, reviews and studies of deaths in custody conducted by the Office since 2007. Gaps in monitoring, response and information sharing are part of a series of persistent and known risks that continue to impede efforts to reduce preventable deaths in custody, including some suicides.

CONCLUSION

> *If you are going to tolerate a few deaths in your jail system, then you've already lost the battle.*[31]

CSC has a duty of care to preserve life and prevent deaths in custody. Identifying and safely managing individuals at risk of taking their own life behind bars is challenging work, but it is not impossible. A major though incalculable obstacle to CSC's prevention efforts remains an organizational belief that prison suicides are rare, isolated or unexpected. In most post-incident reviews of prison suicides, there is a sense that nothing further could have been done to prevent a suicidal, mentally ill or self-injurious inmate with access to means and method from taking their own life. The impression remains that most suicide deaths in custody, however tragic or pre-indicative, are simply beyond the reach of current prevention or corrective measures.

A major impediment to progress appears to be the lack of immediate and substantive follow-up, especially dissemination of lessons learned from boards of investigation across a very decentralized Service. The fact that corrective measures are brought forward to senior management normally several months (or even years) after the incident invariably raises the likelihood that the same organizational shortcomings are permitted to be perpetuated over and over again. Focused almost exclusively on operational compliance, audits and post-incident investigations pay surprisingly little attention to organizational risks and environmental hazards (e.g. access to mental health treatment and supports, segregation as an independent variable, access to in-cell suspension points) that should have been reasonably expected to have been mitigated. After-all, the point of conducting retrospective investigations is to use their findings to make adjustments and corrections so that future similar events can be averted or avoided.

In retrospect, few if any of the suicides reviewed by this Office can be considered 'clean,' or purely impulsive in nature. Indeed, in the majority of cases, there were either known immediate events (within 24 hours of the incident) or proximal to the incident (within one week) as well as other

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[31] As cited in Hayes, op. cit. (2013).

circumstances, risks or influences that indicated suicidal intent. Lessons learned from even a single suicide should have a lasting impact on the organization and its efforts to prevent and publicly account for deaths in custody. Post-incident investigations should drive needed transparency and accountability reforms that would include, among other measures, sharing board of investigation reports with designated family members, making such reports public and routinely providing them to provincial Coroner and Medical Examiner offices even if the incident under investigation does not go to inquest or public fatality inquiry.

The Office's review of 30 recent suicides suggests that progress at preventing prison suicides is still possible, achievable ... and necessary. The accompanying case summaries highlight risks, circumstances and shortcomings derived from the findings of CSC's own boards of investigations. Properly identified and mitigated, there is the potential that these events and factors could have led to other possibilities than precipitating death. To that end, the following corrective measure recommendations are being made to potentially avert similar future deaths in custody.

RECOMMENDATIONS

1. **As a matter of immediate priority, CSC should remove all known suspension points in segregation cells across the country. Where this is deemed technically or economically unfeasible, such cells (or ranges) should be decommissioned.**

2. **Long-term segregation of seriously mentally ill, self-injurious or suicidal inmates should be expressly prohibited.**

3. **CSC should immediately post the *Final Report of the Second Independent Review Committee into Federal Deaths in Custody 2010-2011* as well as its response to the report's findings and recommendations on its external website.**

4. **CSC should continue producing its *Annual Inmate Suicide Reports* or replace it with an annual report that includes analysis of all deaths in custody regardless of cause. This reporting mechanism would include a roll-up of significant findings and recommendations emanating from CSC boards of investigations, mortality reviews of natural cause deaths, as well as**

pertinent issues identified by provincial and territorial Coroner and fatality inquires involving federally sentenced inmates. Corrective measures aimed at mitigating organizational risk should be a prominent feature of these public progress reports.

5. CSC should compile and publish, in one comprehensive evergreen document, the various components of its suicide awareness and prevention program/strategy.

6. A national effort, led by Health Services, should identify inmates at elevated risk of suicide who are held in long-term segregation or have a history of repeated placements and develop appropriate mitigating measures to be shared with operational sites.

7. The Regional Complex Mental Health Committees should directly oversee the treatment and management plans of inmates on active suicide watch or mental health monitoring placed in segregation, observation, psychiatric or behavioural cells.

8. Psychological autopsies conducted in the course of investigations into prison suicides should be expanded to determine possible underlying causes and comparative profiles of other inmates who had committed suicide.

9. Beyond compliance, boards of investigation into prison suicides should be encouraged to focus on identifying organizational gaps and environmental risks (e.g. access to means to commit suicide) that could potentially prevent similar future deaths.

10. CSC should routinely share boards of investigations with designated family members as well provincial and territorial Coroner and Medical Examiner Offices regardless of whether the death goes to inquest or public fatality inquiry.

11. All staff training across the Service, including induction, refresher and upgrading, should contain more practical focus on mental health issues and concerns in corrections. In-class training should be delivered in a live and interactive manner by mental health professionals with the aim of assisting security staff to identify and safely manage self-injurious, mentally disordered or suicidal inmates.

Two other recommendations from previous reports and investigations by this Office remain relevant and should be considered in context of a comprehensive and substantive response:

I. **CSC should create a dedicated senior management position exclusively responsible for promoting, monitoring and ensuring Safe Custody practices.** (*Final Assessment of the Correctional Service of Canada's Response to Deaths in Custody*, September 2010, and *2011-12 Annual Report of the Office of the Correctional Investigator*).

II. **The Minister of Public Safety should create an independent national advisory forum drawn from experts, practitioners and stakeholder groups to review trends, share lessons learned and suggest research that will reduce the number and rate of deaths in custody in Canada.** (*2012-13 Annual Report of the Office of the Correctional Investigator*).

ANNEX

CASE SUMMARIES

CASE SUMMARY NO. 1
SUICIDE BY HANGING OF A LIFE SENTENCED INMATE

Background

A correctional staff member on a routine security patrol found an inmate hanging in his double-bunked cell from the upper bunk bed frame.

The inmate was a new admission and was being assessed for penitentiary placement. He was relatively unknown to staff members as it was his first federal term of incarceration. He was serving a life sentence, though he had served numerous provincial periods of incarceration and probation.

Inmate Profile

The inmate was homeless and transient, estranged from his family, had a substantial history of substance abuse and was diagnosed with a psychotic disorder. The inmate had complications with diabetes and was non-compliant with treatment.

The inmate had recently confessed to murder and was subsequently charged.

He had attempted suicide on at least two prior occasions.

Events Preceding the Death

The inmate consistently denied both suicidal ideations and previous attempts during intake screening assessments and interviews with healthcare professionals.

A non-urgent referral to the Psychology Department was completed due to "weird" behaviour during his immediate needs assessment at time of admission. He eventually saw a mental health professional and was deemed asymptomatic. However, a non-urgent mental health referral was completed and a request was also made for the inmate to be seen weekly in the Mental Health Unit.

The inmate missed two opportunities to participate in mental health intake screening due to participation in other medical appointments.

A cellmate noticed a change in the inmate's behaviour when he stopped going out for recreation after the first week of incarceration and that he was sleeping a lot.

The inmate had been seen by health services for treatment of a chronic medical condition in the morning of the day that he committed suicide. He was also seen in the meal line and appeared well at that time. He committed suicide not long after his cellmate left to go out into the recreation yard.

CSC National Board of Investigation (NBOI) Findings

The NBOI concluded that there were not any immediate precipitating factors to the inmate's suicide and that there was no known information which indicated that he was at imminent risk for suicide. There were, however, long-standing (i.e. mental illness, familial isolation) and proximal precipitating (social and cultural isolation, medical condition and non-compliance with treatment) factors that were known to CSC.

Psychology, Health Services and the Mental Health Unit were not aware of information documenting the inmate's previous history of suicide attempts. While information regarding previous suicide attempts was eventually retrieved, it was not immediately provided to the appropriate healthcare professionals.

While Suicide Risk/Mental Health Assessment and Referral Screenings and Intake Health Care Assessments/Clinical Intake Assessments were completed, they were based on the inmate's self-report and were not informed by information received from provincial authorities. As well, the Health Services interview was found to be conducted in a crowded area, hurried, non-confidential and without appropriate review of collateral information.

CSC NBOI Recommendations (two of four)

CSC should negotiate a memorandum of understanding with provincial correctional authorities to provide health information 24 hours prior to an inmate's transfer.

CSC should develop a process to ensure critical information (e.g. psychological and psychiatric reports, mental health information) is shared with the appropriate staff prior to the completion of assessments.

OCI Summary of Concerns

Identification of suicide indicators
Information sharing
Need for immediate retrieval of relevant information

CASE SUMMARY NO. 2
SUICIDE BY HANGING OF AN ABORIGINAL INMATE

Background

During a routine security patrol, the inmate was found hanging from his cell door bars. It was the eve of his 30th birthday.

The inmate had a lengthy criminal history and his crimes appeared to escalate in terms of violence. At the time of his death, he was serving his second federal term in a maximum security institution.

Inmate Profile

The inmate began sniffing solvents at a very young age after the death of his father. He later began using marijuana and then alcohol. He had been violent toward animals when he was young.

The inmate reported being physically abused by family members. He also disclosed that he was sexually abused by two different men (strangers) on two different occasions but was too afraid to report the incidents.

The inmate displayed behavioural problems such as hostility and anger and reported incidents of domestic violence.

There were no known suicide attempts while in federal custody and he did not display thoughts of suicide. However, there were two self-reported suicide attempts that occurred in the community.

Events Preceding the Death

Immediate Needs–Suicide Assessments completed at two institutions were negative for all suicidal indicators. The inmate indicated that he was last suicidal while in provincial custody. However, previous suicide attempts were not deemed significant in terms of predicting future attempts as they were considered to be in the distant past.
The inmate refused to participate in programming and was not compliant with his Correctional Plan. He rarely saw Health Care or Psychology, though he had regular contact with the Liaison Officer and the Elder.

An Elder saw the inmate a few weeks prior to the suicide and did not notice any changes or issues. He reported that the inmate was "smiling and good".

On the day the inmate committed suicide, he made a number of phone calls, later determined to be made to family members after which he appeared upset (as reported by another inmate). The inmate then returned to the common area and gave a deck of

cards to another offender and told him not to get involved in gambling. This was unknown to staff prior to the suicide.

CSC National Board of Investigation (NBOI) Findings

The NBOI discovered that there were no pre-indicators, precipitating events or contributing risk factors that were known to staff.

The inmate's Aboriginal Social History was not considered during his last annual security level classification.

CSC NBOI Recommendations

Training should be provided to CSC staff on how to incorporate the Aboriginal Social History into the decision-making process.

OCI Summary of Concerns

Consideration of Aboriginal Social History

CASE SUMMARY NO. 3
SUICIDE BY ASPHYXIATION OF A FIRST TIME FEDERAL INMATE

Background

During a routine security round in the segregation unit, a correctional officer discovered the inmate lying face down under his bed in his cell. Once pulled out from under his bed, the inmate was found with his head covered by a towel and plastic bag, secured with an electrical cord. A suicide note was later found in his cell.

A first time federal offender, the inmate had no prior criminal history.

Offender Profile

The inmate had a lengthy career working in various professions until health complications necessitated his departure on disability. He reportedly took great pride in his work and employment success.

The inmate had a long history of serious medical conditions and required medications to alleviate pain, which reportedly led to abuse of other substances.

He had a history of psychiatric treatment for depression and anxiety related to his medical conditions and although he admitted to periodic suicidal ideation, he consistently denied intent or behaviours.

The inmate recently lost his mother (with whom he was very close), had previously lost his father and a sister and was estranged from his brothers. He also lost a number of close friends to illness or abandonment (after he was charged).

Events Preceding the Death

The inmate was involuntarily housed in administrative segregation for most of his time in federal custody due to concerns for his safety. His segregation status was maintained after an intra-regional transfer, which he reportedly found frustrating. He was awaiting an involuntary inter-regional transfer to relieve his long-term segregation status. He had submitted a rebuttal to the inter-regional transfer.

The inmate's initial security classification as calculated by the Custody Rating Scale indicated a minimum security classification, which was subsequently over-ridden.

The inmate was assigned the job of segregation cleaner/server, however several inmates objected and continuously harassed him. Prior to his death, the inmate voluntarily resigned from his job.

The inmate was seen daily by Healthcare Nurses, Correctional Officers and a Correctional Manager. However, his overall level of physical health continued to deteriorate, though he did not request any medical assistance. He also had regular Segregation Reviews which revealed no suicidal ideations or concerns. He was seen by a Mental Health professional a few days before his death and no concerns were noted.

The inmate's anti-anxiety and anti-depressant medications had recently been changed or temporarily discontinued (within 6 weeks of his death).

CSC National Board of Investigation (NBOI) Findings

The Board did not identify any pre-incident indicators to the incident under investigation and found no evidence to suggest that staff were aware the inmate was contemplating suicide. However, the Board identified a number of precipitating and contributing factors, though it was found that these factors were appropriately addressed.

The inmate did not participate in an Intake Psychological Assessment due to the existence of a Court ordered psychological assessment; however the Court report was found to have factual inaccuracies.

The Assessment for Decision with respect to Security Classification and Penitentiary Placement was not completed using all relevant and accurate information which resulted in inaccurate ratings on some critical items. While the Board agreed that his security classification was consistent with policy, they also noted that the inmate could have been managed in a minimum security institution, which would have alleviated his long-term segregation status and the need for an involuntary inter-regional transfer.

Security rounds were not consistently completed; some security patrols did not include all punch stations and some were not completed at least every sixty minutes from the beginning of the last security patrol.

CSC NBOI Recommendations

CSC should institute a quality review process of Offender Security Level/Custody Rating Scale (CRS) concordance rates to assess and remediate local factors which contribute to the high rate of CRS overrides. Further, CSC should commission a national study to identify the factors which contribute to concordance rate discrepancies between the CRS and Offender Security Level.

Recommendations from the Provincial Inquest

The Regional Director of Health Services should establish Memorandums of Understanding with community hospitals which provide services to CSC inmates to

ensure that Treatment/Intervention summaries are provided to the Escort Officers for delivery to Health Services upon the inmate's return from the Hospital.

Establish Intermediate Mental Health Care Units (one in each region of CSC).

OCI Summary of Concerns

Identification of suicide indicators
Continued and comprehensive monitoring of known indicators/events
Completion of security rounds within timeframe (dynamic security)
Appropriateness of over-riding a security designation
Use of external documents as substitutes for mandated CSC reports

CASE SUMMARY NO. 4
SUICIDE BY ASPHYXIATION OF A FEDERAL OFFENDER

Background

During a routine security patrol in the Segregation Unit, a Correctional Officer discovered the inmate sitting on the floor, leaning against the back wall of the cell with a ligature, fashioned from a bed sheet, around his neck suspended from his cell window. The inmate was serving his third federal term of incarceration.

Offender Profile

The inmate was taken into the care of Social Services when he was very young. He remained in foster care until he was adopted. The inmate's adoptive parents were physically and emotionally abusive and he reported that he had been sexually abused.

The inmate had a lengthy criminal history. His criminal behaviour was directly associated with a substance abuse problem which he participated in to fund his addictions. He began abusing drugs and alcohol in his early teens, including cocaine and heroin. His adoptive parents dissolved the adoption when he was a teenager.

The inmate had a long history (since childhood) of self-harming behaviours, primarily as a coping strategy to deal with frustration and anger. He had attempted suicide on numerous occasions. He also had a number of documented mental health issues.

Events Preceding the Death

The inmate was placed at a treatment centre shortly after his admission to CSC for assessment and treatment due to mental health concerns. He remained there for approximately six and a half months and was making progress before being transferred to his parent institution. During transport and upon arrival at his parent institution, the inmate was extremely upset and distraught (about the transfer as he felt safe at the Treatment Centre) and threatened to commit acts of self-harm. He was placed in an observation cell.

He continued to be troubled by his transfer and regularly expressed frustration over it. He was also concerned that his mental health would deteriorate if he continued to stay in an observation cell. Eventually, he was involuntarily segregated (for 43 days).

While at the treatment centre, a prescription for mental health issues was changed to one with a documented adverse effect of suicide.

The inmate had a number of medical concerns and was being treated for them while at the treatment centre. However these treatments ceased after his transfer to his parent institution causing the inmate frustration and anxiety. As well, his previously identified

mental health concerns were not being addressed by CSC clinicians. His mental health monitoring status was removed about a month and a half before his attempted suicide.

Leading up to his death, the inmate frequently refused to eat or take his medications and at one point used ketchup to write "Die" and "Death" on his cell walls. He had also engaged in numerous incidents of self-injury, none of which were appropriately classified as self-injury.

Three days before his suicide, the inmate was informed that he was being considered for an inter-regional transfer to alleviate his segregation status. He expressed concern regarding the imminent transfer as he would no longer have community support.

The day before his death, the inmate had engaged in self-injury that was serious enough to warrant further evaluation and treatment at the community hospital. This incident of self-injury was not reported to a mental health professional and not appropriately followed up when it did come to the attention of a mental health professional. Consequently, the inmate's risk for a further act of self-injury was not assessed.

On the evening of his suicide attempt, the inmate spoke to a family member and complained about his placement at the institution. He did not want to be at the institution and felt as though "no one cared".

Approximately one hour before his suicide attempt, the inmate was served with a charge sheet for damaging government property the previous day.

CSC National Board of Investigation (NBOI) Findings

The incident of self-injury the day before the inmate's death was a pre-incident indicator to the eventual suicide and had this incident been appropriately followed-up, the staff could have intervened and prevented the suicide. CSC staff misunderstood the meaning of the inmate's self-injurious behaviour and felt as though it was manipulative in nature and used as a way to go back to the treatment centre, thus undermining intervention strategies.

Communication and information sharing were found to be problematic between institutions after the inmate's transfer. Information that was eventually shared was inaccurate and inconsistent.

At the time of his death, the inmate did not have a clinical management plan which addressed his suicidal/self-injurious behaviour and was not subject to any additional monitoring other than that which accrued as a result of his placement in segregation.

OCI Summary of Concerns

Identification of suicide indicators
Misunderstanding amongst CSC staff of intent of self-injury
Information sharing failures

CASE SUMMARY NO. 5
SUICIDE BY ASPHYXIATION OF A FIRST TIME FEDERAL INMATE

Background

An inmate was found hanging by a strip of bed sheet from a heating vent on the wall of his cell by a Correctional Officer who was completing a security patrol of the Segregation unit. He died two weeks before his Statutory Release Date.

The inmate was serving his first federal sentence in a medium security institution.

Offender Profile

While the inmate had a close relationship with his mother, he had not had contact with his father for a number of years. The inmate was not a Canadian citizen.

The inmate had a long criminal history. He had a number of convictions as a youth and as an adult which both resulted in periods of incarceration. He often resorted to criminal activity to supplement his meagre income.

He was diagnosed as suffering from an acute mental illness. Periods of hospitalization for his mental health issues were required primarily as result of non-compliance with his prescribed medication.

The inmate had three previous incidents of self-harm and had a history of substance abuse.

Events Preceding the Death

The inmate's most recent conviction resulted in the issuance of a Deportation Order by Immigration Canada. He was preoccupied with the possibility of deportation and was making efforts to appeal the order.

After being penitentiary placed to a medium security institution, he was subsequently transferred (after approximately five months) to a Regional Treatment Centre (RTC) as a result of deteriorating mental health. He spent eight months at the RTC where he was stabilized and presented no further mental health issues.

After being discharged from the RTC, the inmate was transferred to an institution in another region at his own request to be in close proximity to his family. During the transfer flight, medications prescribed for his mental health issues were not administered to him.

The inmate took his life after only a few days at his new institution. During that time, he repeatedly told CSC staff about his anxiety regarding his missed medication. He also

voiced concerns over his proximity to so many other inmates in the general population and more specifically that he had been the subject of muscling and harassment. The types and dosages of the inmate's prescribed medication were changed upon arrival from the RTC.

The inmate was informed by a nurse about the changes to his medications which increased his anxiety levels. He requested to be placed in segregation and it was agreed that segregation would be sufficient to manage his current mental health issues.

Two days before his death, the inmate expressed concerns regarding disorganized and racing thoughts in his head to a nurse, though he indicated he was not suicidal. A referral was made to a mental health practitioner; however, he was not seen before his death as it was not indicated to be an urgent case.

The inmate made two unsuccessful attempts to contact his father over a span of 5 days.

CSC National Board of Investigation (NBOI) Findings

There were no pre-incident indicators prior to the inmate's death though there were three potential precipitating events (anxiety as a result of his transfer, anxiety with respect to missed medications during the transfer and changes to his medications upon arrival at the new institution and an outstanding deportation order).

The Correctional Officer who was completing the security patrol of the Segregation Unit did not immediately call for assistance, resulting in a delay of approximately five minutes in starting resuscitation efforts.

CSC NBOI Recommendations

CSC should review the need for the implementation of policy to ensure a means of administering and documenting the administration of prescribed medications during inmate transfers. CSC should develop a process to ensure that the chain of custody of inmates' medications during transfers can be maintained and followed-up.

OCI Summary of Concerns

Mental health care (administration of medication and impact of changing medications and dosages)
Continuity of care during transfers

CASE SUMMARY NO. 6
SUICIDE BY EXSANGUINATION OF A LIFE SENTENCED INMATE

Background

A Correctional Officer responded to a cell call in the Segregation Unit and found the inmate "thrashing about" on the floor of his cell, bleeding heavily and crying out. The inmate grabbed onto the bed frame when responding Officers attempted to move him out of a pool of blood to begin first aid. He continued to be combative. Staff handcuffed him to allow them to begin treatment. The inmate had used a razor blade secured to two craft sticks with dental floss to inflict the fatal injury.

A suicide note of apology was left for the Psychologist as well as written messages on the wall condemning the prison system.

The inmate was a first time federal offender serving a life sentence, though he had numerous provincial convictions.

Offender Profile

The inmate was physically abused as a child and led a very isolated life. His closest relationship was with his mother who had died a number of years before his death. He was estranged from all but one of his siblings.

The inmate abused alcohol and was intoxicated during each of his multiple convictions. Most of his crimes were perpetuated to fund his alcohol abuse.

The inmate was diagnosed with a mental illness and had a lengthy history of suicidal ideation and attempts as well as self-harming behaviour. He often threatened, attempted and completed self-harm incidents when faced with an involuntary transfer or fearful situations.

Events Preceding the Death

The inmate was anxious about his future placement (he was currently in Segregation) as he was not able to reintegrate back into the general population.

Approximately a month and half before his death, the inmate was being harassed by other inmates and was assaulted by one of those harassing him. The inmate refused to go to the yard for exercise as he feared for his life and attempted suicide two days after the assault.

Less than a month before his death, the inmate disclosed that he was "planning to kill himself in the shower by cutting his jugular vein with a razor."

A personal item to which the inmate had a strong emotional attachment had been lost during a cell transfer and the inmate had been informed, the day before his death, that staff were not able to locate it.

On the day before his death, the inmate engaged in a mental health counselling session to reduce his thoughts of suicide as a result of the loss of a personal item. At the end of the session, the inmate "contracted safety" with a mental health professional the Psychologist and agreed to meet with him the following morning.

The inmate secured a blade from a disposable razor during a shower taken earlier on the day of his death. While the institution has a one-for-one razor exchange, Correctional Officers did not notice that a blade was missing from the razor.

CSC National Board of Investigation (NBOI) Findings

The Board identified contributing factors (i.e. history of suicidal ideation/attempts), precipitating factors (loss of a personal possession to which he had a strong emotional attachment), and one immediate pre-incident indicator (securing of a razor blade).

Segregation Officers were not aware of the inmate's state of mind and had limited information regarding the inmate as most shifts were covered by Correctional Officers who were posted to the unit as part of their multi-function rotation. While this did not impact on the emergency medical response, it underscored the disconnect between the inmate and staff members of the Segregation Unit.

There was no indication in the Segregation Log or in the Segregation Unit Logbook that the inmate had been contemplating suicide by means of a razor in the shower.

There was no indication in the Segregation Log or in the Segregation Unit Logbook that the inmate had "contracted safety."

Though the inmate met the criteria for inclusion in the Institutional Mental Health Initiative (IMHI), he only met with the mental health nurse once as the institution had lengthy stretches without such a position.

CSC NBOI Recommendations

A national review should be considered to address the shortfall in institutional resources required to proactively manage offenders with moderate mental health needs who exhibit significant management problems on an ongoing basis and take resources away from other important mental health and psychological services. This review should include the possibility of creating at least one Intermediate Mental Health Care Unit in each CSC region.

OCI Summary of Concerns

Identification of suicide indicators
Information sharing
Continuity of Care

CASE SUMMARY NO. 7
SUICIDE BY ASPHYXIATION OF AN ABORIGINAL INMATE

Background

A Correctional Officer conducting a regular security patrol on an upper tier of the segregation unit discovered the inmate hanging in his cell from a length of coaxial cable. The ligature was attached to an upper portion of the barred front of the cell. A suicide note was later found.

The inmate was serving his first federal sentence and had just completed two months and twenty-three days of his sentence.

Offender Profile

The inmate grew up in a family environment that was violent and one in which both parents abused alcohol. An immediate family member had committed suicide.

As a youth, the inmate developed a substance abuse problem that started with alcohol consumption but included drug use as well.

The inmate had a lengthy criminal history beginning when he was a youth. Most of his crimes as an adult were violent in nature. Substance abuse was often a contributing factor to his assaultive behaviour.

The inmate had an extensive history of self-harm and had attempted suicide on five previous occasions, including on the day he committed his index offence. He was diagnosed with a mental health disorder and had a history of depression.

Events Preceding the Death

Despite a history of diagnosed mental health issues, documented suicide attempts, reports from staff that he was "crying all the time" and the inmate himself reporting that he was hearing voices, the inmate was never assigned to a Mental Health Team member. This was primarily as a result of a lack of resources and information sharing problems. He was not seen by a mental health professional during the last ten weeks of his life.

Two months prior to his death, the use of a drug to reduce impulsivity and depressive symptoms was discontinued. Despite the inmate's insistence that he would only use this particular drug, the medication was still terminated. The inmate's pharmacological profile was not updated after his medication was stopped.

Approximately one month after his medication was terminated, the inmate was involved in fights with two different inmates over a four day period. The fights led to his

placement in segregation, where he remained until his death approximately three weeks later. After the first fight, which resulted in his placement in segregation, the inmate indicated to staff that he was afraid to return to segregation. The inmate committed suicide during his second placement in segregation.

Four days prior to his suicide, the inmate found out that his former common-law wife, was now with another man.

Two days before he died, the inmate had a conversation with the Chaplain where he was despondent and reflected on the implication of his own death, including a reference to what would happen to him if he killed himself. The inmate had calmed considerably by the end of the interview and as such the Chaplain did not report the inmate's comments to a mental health professional or document the interview.

CSC National Board of Investigation (NBOI) Findings

The Board concluded that many relevant historical factors (history of suicide ideation and attempts, substance abuse, etc.) related to the risk of suicide were not adequately assessed. While staff were initially responsive to the risk presented, their oversight and monitoring diminished significantly in a very short period of time.

The Board concluded that there was a general lack of communication among several staff members and there were many missed opportunities to triage the inmate at, minimally a "moderate" or "intensive" level of need for mental health intervention. Limited availability of psychiatric services at the Institution directly contributed to the inmate being removed from all psychotropic medication support.

The Board concluded that the institution lacked the necessary internal procedures to ensure continuity of care, including verifying that an appropriate medication regime is in place, for cases in which an external decision to stop a particular medication had been taken.

CSC NBOI Recommendations

The Board recommended that contract providers having significant contact with inmates be provided with the same training in suicide awareness and prevention that is offered to permanent employees performing similar roles.

OCI Summary of Concerns

Identification of and follow-up on suicide indicators
Information sharing
Resourcing for mental health
Training for contractors
Continuity of care

CASE SUMMARY NO. 8
SUICIDE BY HANGING OF A FIRST TIME FEDERAL INMATE

Background

An inmate was found hanging from the vent in his cell by a ligature made from a bed sheet.

The inmate was serving his first federal sentence and was close to his warrant expiry date.

Inmate Profile

A number of years were added to the inmate's original sentence as a result of offenses committed while incarcerated. A maximum security rating was maintained during his sentence and he was often placed in segregation.

Raised in a difficult family background, he started to show signs of behavioral issues at a very young age, after the death of his brother. He started using drugs and was placed in various youth centers.

After a segregation period of 8 months in a maximum security institution, he started to present high risk self-harming behaviors and was eventually transferred to the Regional mental health centre. His stay was difficult and a decision to transfer him to a maximum security institution in another region was eventually made, but for many reasons never materialized.

Events Preceding the Death

In the last months of his sentence, the inmate's mental state had deteriorated. His mental health treatment team prescribed and adjusted various medications to help him cope with anxiety and his depressive state.

Two weeks before his death, he was placed on segregation status.

On the day of the incident, institutional management decided that the inmate's behavior could no longer be managed in the acute needs range and the inmate had to be moved to segregation.

When moved to regular segregation, staff was not immediately informed that the inmate was on mental health monitoring status or that there was a need to closely and constantly monitor him. Once instructions were given regarding constant surveillance (only a couple of minutes after the inmate was secured in his cell) it was noticed that the inmate had covered his cell door window with excrement and paper.

The staff member assigned to the surveillance of the inmate had no means of communication and had to leave the area to inform his superior of this development. At the same time, another inmate on the range required intervention while the officer in charge of the range was monitoring a third inmate who was using the administrative phone line.

As a result, the inmate was left, without monitoring and with access to a means of harming himself (he was left in his cell with his clothing and bedding) for approximately ten minutes.

CSC National Board of Investigation (NBOI) Findings

Pre-indicators and precipitating factors were known to staff. There were serious gaps in the communication of instructions regarding surveillance of the inmate that led to a short period of time where he had the means and opportunity to commit suicide.

The communication gaps between institutions were found to be serious enough to require formal recommendations regarding changes in institutional policies.

The specific point of suspension used by the inmate to commit suicide had been identified by the institution, but it had been decided nothing could be done about it. This decision was questioned by the NBOI.

CSC NBOI Recommendations

CSC should adopt changes to the Commissioner's Directive regarding the management of suicidal and self-harming risk to clarify the nature of various levels of surveillance.

CSC should identify a national sector responsible for ensuring national leadership in the management of efforts to reduce the number of suspension points in cells across the country.

OCI Summary of Concerns

Mental health monitoring
Alternatives to segregation
Information sharing
Continuity of care
Suspension points

CASE SUMMARY NO. 9
SUICIDE BY HANGING

Background

During the morning security patrol, a Correctional Officer found the inmate hanging from a shelf by a bed sheet.

The inmate had been released approximately six months prior but had been suspended

Inmate Profile

The inmate had an extensive criminal background that started with property crimes but escalated in terms of violence over the years.

Having difficulty coping with substance abuse, a mental health disorder and suffering from a degenerative disease, the inmate had previously attempted suicide twice.

Events Preceding the Death

The staff did not notice any difference in the inmate's behavior the days prior to his death. He continued attending daily activities and was examining legal options regarding his situation.

He refused to meet with the nurse and the psychologist upon his suspension but they insisted in meeting with him and noted no suicidal ideations at that time. He was referred to the Mental Health team as a result of his mental health diagnosis.

CSC National Board of Investigation (NBOI) Findings

The Board made no findings of non-compliance or recommendations.

OCI Summary of Concerns

Identification of suicide indicators
Suspension points

CASE SUMMARY NO. 10
SUICIDE BY HANGING OF AN ABORIGINAL INMATE

Background

Correctional staff found the inmate hanging in his cell, from the protective cover of the smoke detector. The emergency interventions were efficient and the inmate was sent by ambulance to a community hospital where he was maintained on life support. He died less than 24 hours later.

The inmate had an extensive history of violence, both against himself and others. He had attempted suicide on six occasions in the year before his death. He was considered a chronic suicide risk and spent most of his incarceration in segregation or segregation-like conditions.

Inmate Profile

The inmate was serving a life sentence since the age of 18.

He was involved in numerous violent incidents against both staff members and other inmates, including hostage taking situations.

Isolation and deprivation resulted in various acts of self-harming behaviour as well as suicide attempts. On numerous occasions, the inmate was placed in an observation cell for long periods of time, sometimes in 4-point restraint chairs. The inmate had been placed in physical restraints on numerous occasions (up to 10 days on one occasion and for almost a month while he was in a hospital). Medications were often injected to calm the inmate when he was in crisis.

The institution required expertise from both Regional and National Headquarters as well as staff from the treatment center to help manage the inmate.

The inmate was admitted for a short stay in a secure psychiatric hospital during his sentence; however his threatening behaviours resulted in his return to a penitentiary. His file was presented for admission at that hospital on two other occasions, but was refused.

Events Preceding the Death

A week before his death, the inmate had self-harmed by cutting his wrists and throat, telling officers to help him and that he wanted to die. His wounds were treated and he was placed in physical restraints where he remained for 27 hours. He was then placed on high suicide watch, but managed to self-harm by banging his head and was again placed in restraints for another 20 hours.

Two days later, the inmate was again placed on high suicide watch in an observation cell for a couple of hours before being placed on modified suicide watch. His situation seemed to improve and his surveillance status was changed to "mental health monitoring".

The day before and on the day of his death, the inmate was seen by health care and correctional staff on a few occasions. He complained of irrepressible anxiety feelings and claimed to have fallen twice on the floor. Less than three hours before being found unconscious, he was provided his medication by a nurse. He appeared calm and disclosed no complaints.

CSC National Board of Investigation (NBOI) Findings

The Board concluded that the inmate's specific needs required a more clinical environment than what the institution could provide. However, the violence and aggressiveness displayed by the inmate limited the available options. The Board further found that the behavioral management plan in place for the inmate was not working as it often resulted in physical isolation of the inmate even when his behaviors were appropriate.

CSC NBOI Recommendations

The Board recommended that when violent behaviour is tied to a serious mental health issue, the inmate (whenever possible) should not be transferred to the Special Handling Unit.

The Board recommended that the interdisciplinary management plan should be re-evaluated in order to ensure that certain punitive forms of interventions be avoided.

The Board recommended more uniformity in national efforts regarding the elimination of suspension points.

OCI Summary of Concerns

Suspension points

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